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DEPARTMENT OF COMMUNITY,
TRADE AND ECONOMIC DEVELOPMENT

Community Mobilization Against Substance Abuse And Violence

2001 – 2002 Annual Report

March 2003

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Director

Community Mobilization Against Substance Abuse And Violence

2001 – 2002 Annual Report

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EXECUTIVE SUMMARY

Community Mobilization Against Substance Abuse and Violence has active community coalitions working throughout Washington. The Community Mobilization (CM) Program was established in 1989 by the Washington State Legislature to address the issues of substance abuse and violence through the organized and collaborative efforts of entire communities.

Community Mobilization provides vision. This report provides information and data about the functions and activities of the statewide CM Program in Washington's 39 counties. The CM Program's vision: **Community members participating in creating and sustaining healthy, safe, and economically viable communities, free from alcohol, tobacco, other drug (ATOD) abuse, violence, and all related social issues.** Local CM Coordinators make this a reality by pursuing CM's mission **to effectively address the problems of ATOD abuse and violence by promoting collaboration, cooperation, communication, commitment, and cultural competency.**

Community Mobilization is a local resource. Since the inception of CM, local CM Coordinators are recognized as their county's central resource point for all prevention efforts[1]. They are the first to be contacted when individuals or organizations have questions about substance abuse or violence prevention because they either have the answers or know the source of those answers[2].

Community Mobilization provides leadership. Successful community-based prevention programs build upon the efforts of a variety of grassroots and locally based organizations. CM promotes prevention efforts dependent upon a community commitment to values and attitudes consistent with a drug- and violence-free environment. CM leadership stimulates change and ensures that prevention efforts are culturally appropriate and effective. One of the most important prevention lessons learned throughout the last two decades is that ***prevention cannot be imposed from the outside; it must be led from inside the community to be effective***[3]. CM brings local leaders to the table.

Community Mobilization is based upon research. CM uses the Communities That Care (CTC) model in promoting the positive development of children and youth, and the prevention of substance abuse and violence. CM is **based on rigorous research** from a variety of fields, including sociology, psychology, education, public health, criminology, medicine, and organizational development[4].

Community Mobilization is locally driven. The CM Program requires an active governing board that represents the local community perspective. The board is involved in the development and implementation of the CM Program's substance abuse reduction strategy. At a minimum, each county must ensure that their board includes representation from education, treatment, law enforcement, local government, and other community organizations.

Community Mobilization is based upon partnerships. CM programs are directly involved in many networking efforts that have developed as a result of community representatives working together to share information. Examples include the Collaborative Needs Assessment, the Prevention Summit, the Washington State Survey of Adolescent Health Behaviors, the Reducing Underage Drinking Coalition, DUI/Traffic Safety Programs, the Washington Association for Substance Abuse and Violence

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[1] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001, p. 12.
[2] Ibid., p. 15.
[3] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc. 2001, p. 31.
[4] Ibid., p. 7.

Prevention, Tobacco Prevention, school partnerships, the National Network for Safe and Drug Free Schools and Communities, and the Governor's Council on Substance Abuse.

***Community Mobilization's success is supported by evaluation*[5].** Beginning in 1996 and continuing through 2000, the Department of Community, Trade and Economic Development (CTED) contracted with Developmental Research and Programs, Inc. (DRP) of Seattle, Washington, to conduct a comprehensive evaluation of the CM program. The CM projects proved to be well integrated within the county-level prevention community, and were often at the center of their county's prevention services. CM activities routinely incorporated high levels of volunteer efforts from other county-level organizations and provided substantial help to other prevention agencies. In addition, CM programs were heavily customized and tailored to fit their unique county setting.

In developing its outcome evaluation methodology, CTED implemented pilot evaluations and provided ongoing support, training and technical assistance to the local CM programs. It was learned that high quality evaluation was possible and already taking place for local CM programs; that measurement instruments either already existed or were being fine-tuned; and that without continued oversight, local CM projects could not sustain the expense and resources needed to conduct their evaluation efforts.

In June 2001, CTED hired a full-time evaluator on staff. During 2001-2002 the new Program Evaluator conducted a qualitative evaluation of the CM Program using in-depth interviewing techniques. This qualitative evaluation found that:[6]

- CM was successful in supporting the development of social groups for prevention, even with limited public resources. Ninety-six percent (96%) of the CM programs were sustained and supported by their local communities.
- Of the 28 CM programs evaluated, 96 percent (96%) appropriately addressed one or more risk and protective factors within the CTC Social Development Model, and 93 percent (93%) addressed the risk and/or protective factors identified through their county's Collaborative Needs Assessment process.

In summary, the evaluation provided additional evidence that CM's use of the CTC Model is successful in lessening the human costs associated with substance abuse and violence, and is therefore a good use of public resources.

Community Mobilization addresses emerging issues. While working on many different aspects of drug abuse and violence problems, CM Coordinators have found that new issues are constantly emerging. CM is in a unique position to help local communities and prevention partners respond to these issues, and state and local CM agencies regularly work together to develop a statewide approach. Emerging issues faced by CM are found within the Collaborative Needs Assessment process, local and statewide networking, outcome measurement, methamphetamine impacts, inadequate and unstable funding, science-based programming, leveraging funding, *Homeland Security*, and ensuring culturally appropriate prevention programming.

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[5] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc. 2001, p. 2.
[6]Daniel M. Amos, Ph.D., *Community Mobilization Prevention Strategies and Outcomes: An Evaluation,* Department of Community, Trade and Economic Development, Olympia, WA, 2003.

INTRODUCTION

COMMUNITY MOBILIZATION WORKS FOR COMMUNITY CHANGE

Community Mobilization Against Substance Abuse and Violence has active community coalitions working in all 39 Washington counties. Community Mobilization (CM) Programs provide the catalyst and coordination necessary to bring community stakeholders and organizations together to develop strategies that counter substance abuse and violence. CM creates and builds on existing efforts to facilitate community change and provide healthy social development experiences for youth and families impacted by substance abuse and violence.

The CM Program was established in 1989 by the Washington State Legislature to address the issues of substance abuse, violence, and related social ills through the organized and collaborative efforts of entire communities. Established within the Washington State Department of Community, Trade and Economic Development (CTED), funding for CM comes from two sources, totaling $3.1 million per year, to ensure a statewide CM prevention presence. Washington State's dedicated Violence Reduction and Drug Enforcement (VRDE) account provides about $1.7 million per year; the Governor's portion of the federal Safe and Drug-Free Schools and Communities (SDFSC) Grant provides another $1.4 million.

This report provides information and data about the function and activities of the statewide CM Program in all of Washington's 39 counties. CTED staff and local CM Coordinators are enthusiastic and passionate about the ongoing successes enjoyed within the local CM Programs. The following pages will describe what the CM Program is really about; that is, *organizing local community members to prevent and reduce substance abuse and violence*.

We will also summarize the key evaluation findings from two recently published evaluation reports of the CM Program and discuss current issues faced by CM. We will describe the unique attributes of CM at the local level; i.e., how local CM Task Forces support treatment, law enforcement, and community organizing, and the unique voice of each community as it works to solve its own substance abuse and violence problems.

WHAT IS COMMUNITY MOBILIZATION?

Effective prevention of alcohol, tobacco, drug use, and violence requires communities to become organized and strongly motivated to meet the challenge. Successful prevention efforts require that a community find a structure and process that encourages a variety of independent, local organizations to cooperate effectively in the delivery of prevention services. In Washington State that structure and process is the CM model.

The CM Program's vision: **Community members participating in creating and sustaining healthy, safe, economically viable communities, free from alcohol, tobacco, other drug (ATOD) abuse, violence, and all related social issues.** Local CM Coordinators make this a reality by pursuing CM's mission **to effectively address the problems of ATOD abuse and violence by promoting: collaboration, cooperation, communication, commitment, and cultural competency.** CM funds and supports local community organizing efforts, services and projects directed toward ATOD, and violence reduction within every county in Washington State.

Since the inception of CM, local CM Coordinators are recognized as their county's central resource point for all prevention efforts[7]. They are the first to be contacted when individuals or organizations have questions about substance abuse or violence prevention because they either have the answers or know the source of those answers[8]. Their interconnections within their counties are major assets in linking organizations and services. In this capacity, CM Programs have become the cornerstone of prevention efforts throughout their counties. The CM Coordinators are the primary linkages among prevention organizations. They assist in the allocation of effort and resources, offer prevention expertise and consulting, ensure coordination of efforts, and generate momentum for passionately organized prevention communities. CM is the only prevention program in the state that requires local community mobilization as a prevention strategy. In some counties, the entire CM funding resource is dedicated to developing and nurturing this community organizing process[9].

Successful community-based prevention programs build upon the efforts of a variety of grassroots and locally based organizations. CM targets specific community needs identified through individual county collaborative needs assessments. Therefore CM promotes prevention efforts dependent upon a community commitment to values and attitudes consistent with a drug- and violence-free environment. Local CM leadership stimulates these changes and ensures that prevention efforts are culturally appropriate and effective. One of the most important prevention lessons learned throughout the last two decades is that ***prevention cannot be imposed from the outside; it must be led from inside the community to be effective***[10]. CM brings local leaders to the table to effectively spearhead this community commitment.

In each county, professionals and community members work together to develop their collaborative needs assessment to identify the highest substance abuse and violence risks prevalent among their communities and to select the protective factors they can implement in preventing these problem behaviors. This locally driven process involves a partnership of local staff from the following state-

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[7] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001, p. 12.
[8] Ibid., p. 15.
[9] Ibid., p. 1.
[10] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 31.

funded programs: CM, school districts, the Department of Social and Health Services/Division of Alcohol and Substance Abuse (DSHS/DASA), the Department of Health (DOH), Driving Under the Influence Task Forces, Community Health and Safety Networks, parents, concerned citizens, and other community organizations.

CM Programming uses the *Communities That Care (CTC)* model in promoting positive development of children and youth, and prevention of substance abuse and violence. CM **inclusively** engages all areas of the community in promoting healthy development. CM **proactively** identifies and addresses priority needs *before young people become involved in problem behaviors*, and targets early indicators instead of waiting until problems become entrenched in young peoples' lives. CM is **based on rigorous research** from a variety of fields, including sociology, psychology, education, public health, criminology, medicine, and organizational development[11]. CM is tailored to each community. Each local CM Program uses its own community's data-driven profile. This profile is developed from the county's collaborative needs assessment process to develop a comprehensive, long-range plan to strengthen existing resources and to fill identified gaps throughout their county.

Robin Posey, Sherry C. Wong, Richard F. Catalano, Ph.D., J. David Hawkins, Ph.D., Linda Dusenbury, Ph.D., and Patricia J. Chappel of Developmental Research and Programs, Inc. developed the *Communities That Care Prevention Strategies: A Research Guide to What Works*. In the early 1980's, J. David Hawkins and Richard F. Catalano also collaborated in conducting a review of thirty years of research on youth substance abuse and delinquency. This CTC model is the foundation of their work on risk and protective factor-focused prevention. Their approach is based on the simple premise that *to prevent a problem from happening, we need to identify the factors that increase the risk of that problem developing, and then find ways to reduce the risk.* This is the foundation upon which each local CM Program is built.

The uniqueness of CM's community organizing role, combined with the *Communities That Care* model and the county collaborative needs assessment process, results in prevention strategies that are locally driven. In this way, CM effectively addresses the specific substance abuse and violence reduction needs of local communities statewide.

Community Partnerships

Community Mobilization's success is largely due to the partnerships it has created. CM Coordinators have strengthened and expanded relationships over the years as they partnered with other community organizations to reduce substance abuse and violence. But experience shows that partnering includes challenges:

- Territorialism: Some organizations want to dominate other agencies' efforts and/or influence the decision-making process to make choices that are contrary to the community's prioritized needs.

- Differing requirements: Expectations of funding sources vary (i.e., Community Networks, DASA, and CM), making it difficult to design comprehensive, inclusive programs. The challenge is to fulfill each funding source's requirements while maximizing each partner's contribution to the whole.

[11] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 7.

- Resource gaps: Gaps may result from funding limitations and requirements or from a simple lack of resources. Important activities are weakened due to a lack of needed components (transportation, childcare, etc.). Sometimes the solution requires seeking partners who may fill these gaps. Creativity is necessary in identifying the resources that can respond to the need.

At the local and state level, CM works to create partnerships with multiple agencies and service providers within and outside of the prevention field. CM is often the catalyst for action in the community. It has been shown that this type of networking requires constant maintenance and assistance in order to thrive. CM contractors prioritize their efforts to ensure that local networking, or *Community Organizing*, receives the support and assistance needed to continue to serve the community.

The CM program requires an active policy board that represents the local community perspective. The board is involved in the development and implementation of the CM Program's substance abuse reduction strategy. At a minimum, each county must ensure that their board includes representation from education, treatment, law enforcement, local government, and other community organizations.

CM programs are directly involved in many networking efforts that have developed as a result of community representatives working together to share information. Examples include:

Collaborative Needs Assessment

Locally, prevention professionals and community members are required by their funding sources to work together in developing a *Collaborative Substance Abuse and Violence Prevention Needs Assessment*. This assessment assists the community partners to identify prevalent substance abuse and violence risk factors and to implement protective factors in prevention of these problem behaviors. This locally driven process involves partnerships among the following programs: CM, Office of Superintendent of Public Instruction (OSPI), DSHS/DASA, DOH, Community Health and Safety Networks, parents, concerned citizens, and community organizations.

The Washington Interagency Network (WIN) requested that, as a part of a larger State Incentive Grant (SIG) evaluation effort, the Collaborative Needs Assessment process be evaluated. Findings included:

- All counties completed a Collaborative Needs Assessment report.
- The assessment resulted in first-time collaboration for some counties. Some of the new workgroups established decided to continue meeting after the report was completed.
- The movement from collaborative assessment to collaborative planning occurred without a break in some counties.
- The vast majority of local partners went to great lengths to collect, analyze, and present data to their peers and community members.

Washington State Prevention Summit

Representatives from all areas of the substance abuse and violence prevention field come together every year in a statewide conference to share expertise and learn about innovative programs. This year's theme was ***"United We Stand – Drug-Free We Soar."*** The conference offered workshops focused on collaborative efforts in prevention theory and science, practical application, innovations, policy and advocacy, systems development, taking research to practice, and advanced prevention

science. The workshop tracks targeted college, school, community, professional, tobacco, youth, and environmental strategies. CM Coordinators were both participants and presenters, highlighting their program practices and current strategies. This very successful annual collaborative event is well attended by members of the prevention field statewide.

Healthy Youth Survey (formerly known as Washington State Survey of Adolescent Health Behaviors)

Every two years, partners from the OSPI, DOH, DSHS/DASA, and CTED come together to jointly sponsor a statewide survey of youth health behaviors. The *Washington State Healthy Youth Survey* is given to school-aged students in grades 6, 8, 10 and 12. It gathers information concerning behaviors that may result in unintentional and intentional injury (e.g., seat belt use, fighting, and weapon carrying); physical activity; dietary behaviors; alcohol, tobacco, and other drug abuse; and related risk and protective factors. Survey data is used as one source of information in developing county-level collaborative needs assessments.

Governor's Council on Substance Abuse (GCOSA)

GCOSA was established by executive order in 1994. CM is one of several key membership areas selected for representation. The Council works with state and local agencies and communities to develop common substance abuse reduction goals and priorities for the majority of prevention providers in the state. It also advises Washington State's Governor on substance abuse issues by providing policy, program, and research recommendations.

Washington Association for Substance Abuse and Violence Prevention (WASAVP)

As the need to strengthen advocacy to reduce substance abuse, violence, and their effects on the citizens and communities of Washington State became critical, CM Coordinators came together and created the *Washington Association for Substance Abuse and Violence Prevention*. These local organizers represented large, small, rural, and urban communities and blended their ideas, strengths, and experiences. The mission of WASAVP is "To unite prevention advocates in Washington State in order to create environments that support safe and healthy communities through the prevention of substance abuse and violence."

Washington State Community DUI/Traffic Safety Programs

Traffic Safety Programs promote safe driving in their respective communities and serve over 85 percent of our state's population. In many counties, CM works directly with, or serves as, these County Coordinators. Services include coordinating emphasis patrol activities, presentations to youth and communities, public information and education, organizing mock crashes, safe prom activities, DUI victim impact panels, and supporting statewide campaigns.

Washington State Coalition to Reduce Underage Drinking (RUAD)

The RUAD Coalition, which serves as the advisory committee to the RUAD Policy Council and, ultimately, to the Governor, provides local grant funds to reduce underage drinking. The State Coalition was chartered to provide policy input and implement guidance to the RUAD Program. CM is a Coalition member at both the state and local levels. As such, CM works with other state agencies, community groups, law enforcement, and youth to systematically address underage drinking.

Department of Health/Tobacco Prevention

CM Coordinators play a large role in tobacco prevention. CM is involved with DOH boards in the facilitation of training, such as *Teens Against Tobacco Use* for students, and participation in public service announcements. In several counties, CM Coordinators are also the Tobacco Prevention Providers. They work closely with local schools, assisting Prevention/Intervention Specialists with materials needed for students and providing educational material for classroom teachers. In some counties, CM Coordinators serve on their county's tobacco coalitions, which are responsible for programs and strategies for use of tobacco settlement funding.

The National Network for Safe and Drug Free Schools and Communities

The passion reflected by the local CM Coordinators who created WASAVP was mirrored at the state level when representatives from many of the states' Safe and Drug Free Schools and Communities Program federal grant came together and formed the *National Network for Safe and Drug Free Schools and Communities* (Network). Comprised of state-level school and governor's-portion administrators, the Network meets twice a year in Washington, D.C., and consistently enjoys attendance from no less than 30 states. Attendees at Network meetings share program implementation issues and expertise, seek problem resolution, and work to ensure that information about the program's successes is communicated to all policy levels. State-level CM staff played an active role in the Network, assuring that the states had input into the recently passed program reauthorization.

School Partnerships

Partnership is the appropriate description for CM in the school system. Statewide, school referrals consistently make up no less than 43 percent of local CM participants, as reflected by local Program Activity Reports. CM is considered by Prevention Specialists to be their main resource[12]. CM offers services that include prevention education, video rentals, school notification regarding activities such as the statewide poster contest, assistance with activities such as the "Mock Crash", providing classroom educational materials, data for grant writing, and availability to schools for any questions concerning prevention.

CM assists Middle School Coordinators with information concerning needs assessments, laws and regulations related to prevention, and new laws and/or concerns. A Middle School Coordinator's focus is on parent and community involvement with their respective schools, thereby making the relationship between themselves and CM of great importance.

[12] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001, p. 12.

COMMUNITY MOBILIZATION'S EVALUATION EFFORTS

The Foundation of CM's Past Process Evaluation Efforts

Process evaluation is the most basic form of program evaluation. It examines the formation, development, and operations of a program. It includes whom the program serves, what kinds of services are delivered, how material and personnel resources are allocated, and the effectiveness of the program's management.

The CM Program's process evaluation efforts are dynamic and continue to evolve. Local CM Coordinators must provide an annual action plan and timeline for all planned activities, and are required to submit semi-annual Program Activity Reports (PAR forms) documenting their risk and protective-factor-based activities.

In 1996, CTED contracted with Developmental Research and Programs, Inc. (DRP) to conduct a comprehensive evaluation of the CM program. A long-term process and outcome evaluation plan was developed and implemented. The evaluation was completed in 2001[13].

Two distinct process evaluation efforts were implemented. During 1996-98, basic information on program operations was provided. Then, a network analysis specifically investigating the community mobilizing functions of the local CM projects was conducted in 1999-2001[14].

Process Evaluation Goals

1. Document the current program operations
2. Continue the process of putting the CM Program on a sound research base
3. Develop recommendations for program improvement
4. Develop new data collection methods to relieve CM Coordinators of administrative burden and support ongoing process evaluation
5. Provide training on the purposes, methods, and benefits of evaluation

The CM projects proved to be well integrated within the county-level prevention community. They often are at the center of their county's prevention services. CM project activities routinely incorporate high levels of volunteer efforts from other county-level organizations and provide substantial help to other prevention agencies. They play a significant and visible role in county organizational networks. Evaluation activities have a broad audience beyond the CM staff and contractors. There are multiple stakeholders in CM evaluation projects. In addition, it was found that CM programs are heavily customized and tailored to fit their unique county setting. CM serves a broad cross section of Washington's adults and children.

We also learned that many CM programs conducted activities that were inherently difficult to evaluate. This aspect of evaluation was not fully appreciated at the start of the evaluation process. CM contractors operate on shoestring budgets. These limited budgets make it difficult for CM contractors to build sustainable and lasting programs.

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[13] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 2.

[14] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., p. 9.

Recommendations included:

- CTED continue to allow substantial local control in program design.
- CTED provide training and technical support for CM Coordinators in protective factors, measurement, and evaluation.
- CTED improve documentation of local prevention activities, and demonstrate their relationship to the risk and protective factor model.

The Network Analysis[15]

In 2000-2001, CM county prevention efforts were quantitatively measured using a research method called "network analysis." The central role played by CM in the countywide prevention process was examined.

Successful community based prevention programs build upon a variety of organizational efforts. They depend on the community's commitment to values and attitudes consistent with a drug- and violence-free environment. Effectively changing community attitudes and norms require local leaders to organize prevention efforts. Local leadership has more influence, and it ensures prevention efforts are culturally appropriate and effective. Prevention cannot be imposed from the outside—it must be led from inside the community to be effective[16].

The Community Prevention Infrastructure

The CM Program specifically addresses the need for communities to develop a locally based "community prevention infrastructure" (CPI) that supports a vigorous and coordinated prevention effort, reaching all segments of the community. This CPI is the natural outgrowth of a healthy community mobilization process. Some CM contractors dedicate all their resources to the development and nurturance of the local community mobilization process. These contractors do not provide any direct services to county residents – they are committed to reducing substance abuse and violence in the communities by strengthening their local CPI. An effective CPI supports prevention programs through a number of concrete methods:

- Helping local prevention organizations identify at-risk populations.
- Introducing new prevention organizations to important community gatekeepers.
- Helping prevention organizations accurately assess county resources and levels of service, and reduce duplication of efforts.
- Assisting new programs in identifying effective prevention activities.

Aspects of Network Analysis

Three characteristics of the social network comprised of prevention related organizations in each county were investigated: ***density***, ***organizational centrality***, and ***clique membership***. Results from each of the core survey items were analyzed to assess each of these characteristics (which are described below). All three characteristics provide information on the relative strength of the network

[15] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001.
[16] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 31.

as a whole, and on the involvement and importance of the CM organization within the prevention network.

Results

Density Analysis

Density is a measure of the number of connections one organization has with other organizations. Specific to CM organizations, a clear pattern of results is evident in the density analyses. Results indicate that CM organizations are consistently rated higher on the density measure than the average prevention organization. The density measurement for the CM organizations that participated was 76 percent. This means that CM programs were recognized by three-fourths of the respondents, which is significantly higher than was found for the average prevention organization in the studied counties. CM organizations play a significant and visible role in the county prevention network.

Organizational Centrality

Organizational centrality measures the relationship between CM Contractors and other agencies within the community. It calculates the number of direct interconnections (or links) that an organization provides between other organizations. This measure is particularly sensitive to organizational operations that typically link different players within the prevention infrastructure. CM contractors are average, or above average, when compared to other prevention organizations in the county.

The centrality measure also captures events where an agency serves as an indirect link between two other organizations. In this case, CM plays a role in linking up organizations or brokering services.

Clique Membership

Cliques are groups of organizations that share a dense volume of contacts among themselves. Results of the clique analyses mirror those of centrality analyses. The level of interconnectedness is inversely related to the intensity of the involvement. CM contractors are as involved, or more involved, than the average county prevention organization, as measured by the number of clique memberships.

Summary and Discussion

The results of this analysis indicate that county-level CM contractors play a prominent role in county-level prevention. Analysis results were favorable for the CM projects in each of the network analyses: density, organizational centrality, and clique membership. Favorable CM findings were consistently reported at the varying levels of coordination among county-level prevention organizations.

These results confirm that county-level CM contractors play an important role in the development and support of the county-level prevention infrastructure. CM maintains a very visible profile, one that stands above other county-level prevention organizations.[17]

[17] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc. p. 15.

The Program Activity Report (PAR)

The Program Activity Report (PAR) was developed in cooperation with the Division of Alcohol and Substance Abuse (DASA). Results of each year's data can be found in the annual reports produced for those years. In the summer of 2002, the on-line database was developed and training was provided to CM contractors. Program Activity Reports for each service, program, or project are submitted semi-annually. Over the space of the program year (July to June), 541 reports were generated statewide. The following is information gleaned from those reports.

When the reporting system was made accessible by Internet access, the form was changed to allow for more detailed information than had been previously gathered. For this reason, not all numbers are comparable to previous years.

Unduplicated Participant Count: One example of such a change referred to above is the unduplicated participant count. Previously, there had been no distinction between ongoing programs or projects and one-time, large events. Nor had there been information collected concerning the use of media or distribution of literature.

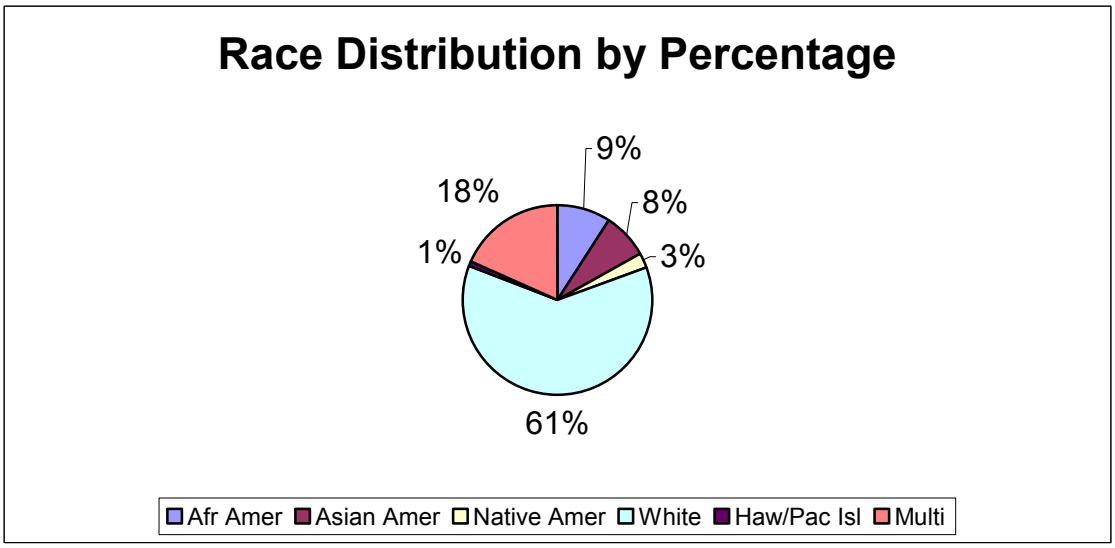
If participants had been counted as in previous years, there would have been 459,009 participants served. This would have included 213,853 participants enrolled in continuing programs or projects, and 245,156 participants attending one-time, large events. The 213,853 participants were provided with 89,907 direct hours of service in 34,549 distinct sessions. Contractors spent a total of 74,067 hours in preparation to provide these services.

Beginning this year, new data has been collected in regard to the use of media and literature. There were approximately 864,186 individuals who received services through media connections (TV, radio, newspaper articles, etc.). Over 337,210 pieces of literature were distributed to community members.

Ethnic Distribution: When providing service, CM programs prioritize at-risk youth and communities.

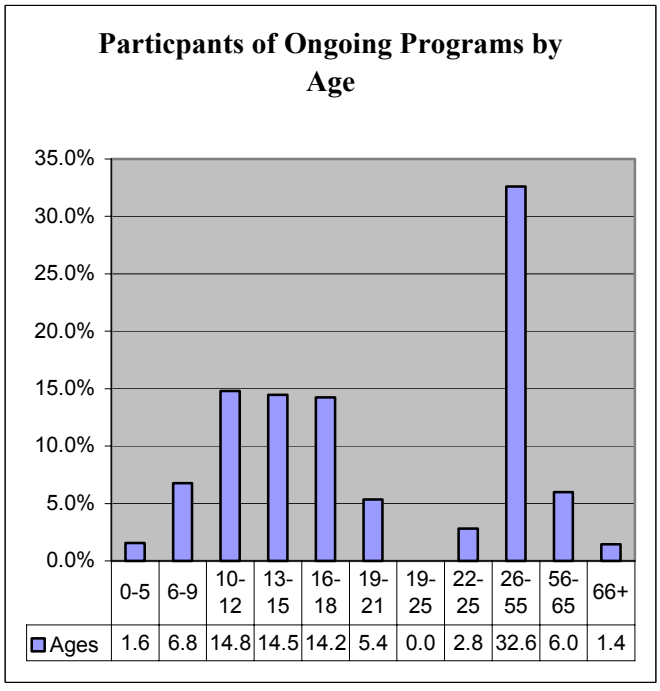
- People of color and ethnicity make up 39 percent of the participants in ongoing programs and projects. The state average is 11 percent.
- Asian Americans make up the largest group of participants, 18 percent of the total. They comprise only 4 percent of the total state population.
- African Americans account for 9 percent of the population served, while they represent only 3 percent of the statewide population.
- Native American representation in CM programs is 3 percent, as compared to 2 percent of the statewide population.
- People of Hispanic origins (regardless of ethnicity) make up 18 percent of the total population served. This group comprises only 6 percent of the statewide population.

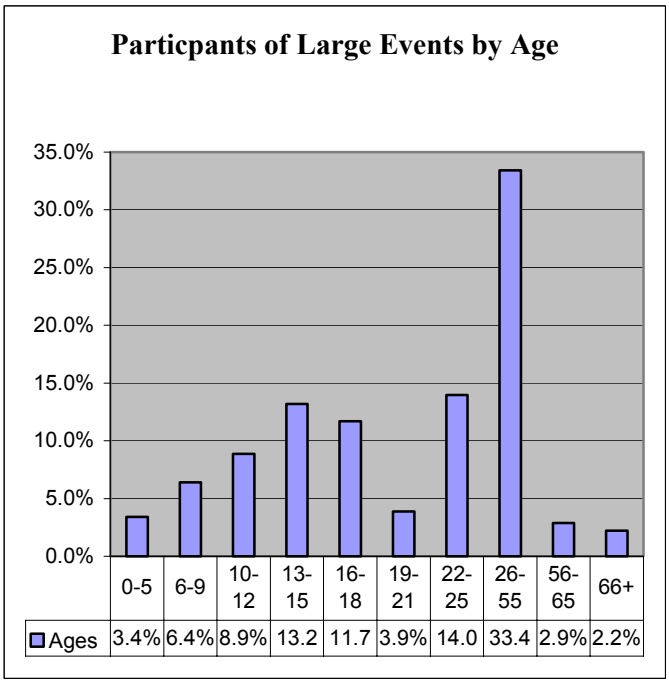
These statistics indicate that CM is successful in reaching members of various ethnic groups within their communities.



Age distribution: Of the total population of participants served in ongoing programs, 43 percent are youth between the ages of 10 and 18. This is in keeping with CM's priority to serve youth, particularly those at risk. Another significant group are those between the ages of 22 and 55 (35.4 percent). These are primarily parents, teachers, and other professionals who care for, or provide services to youth.

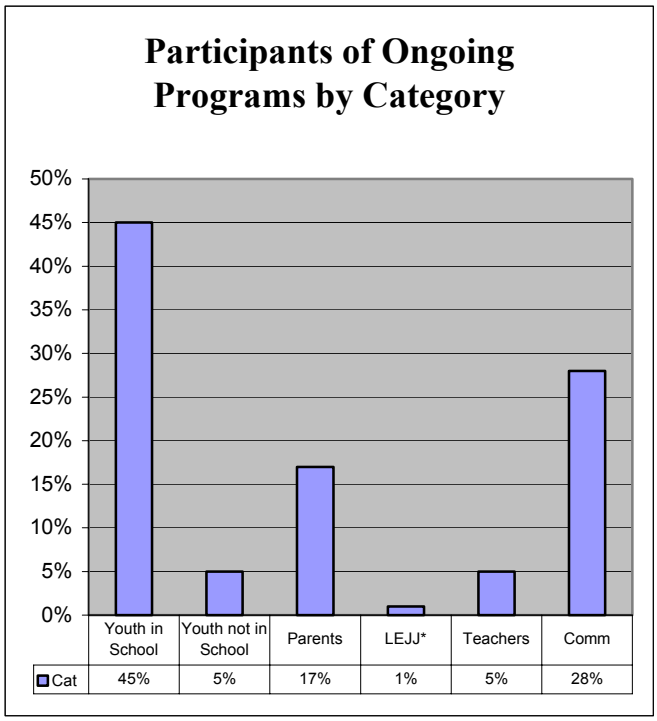
For large, one-time events, 33.8 percent of the total population served was youth between the ages of 10 and 18. Adults between the ages of 22 and 55 accounted for another 47.7 percent. Large events include health fairs, community forums, Substance Abuse Rallies (such as MADD, or the Annual Smoke-Out), and other events that focus on the community at large.

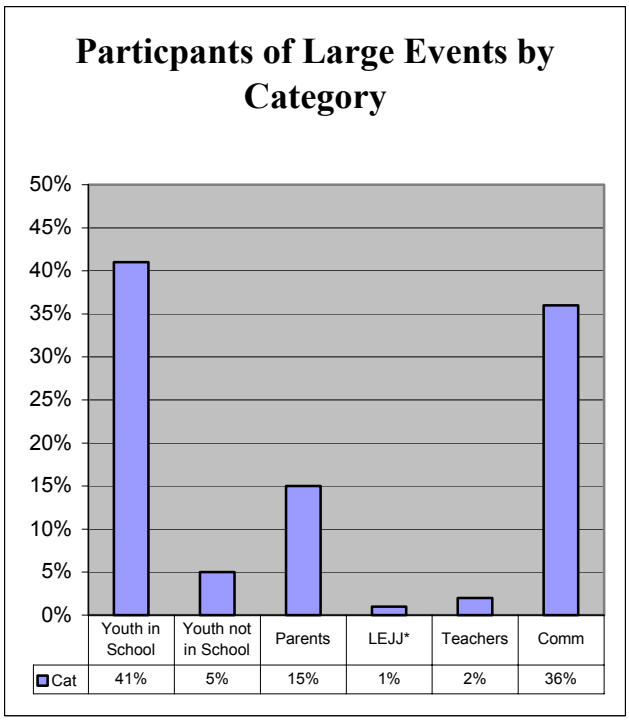




The percentage of participants by service category shows the make-up of the youth and adult population. It compares the number of youth in school that is served (45 percent for ongoing programs

and 41percent for large events) to youth not in school (5 percent in both). It also delineates the categories of adults served: parents (17 percent for ongoing and 13 percent for large events), law enforcement (1 percent**),** teachers (5 and 2 percent respectively**),** and community members (2.8 and 3.4 percent).





Risk and Protective Factors

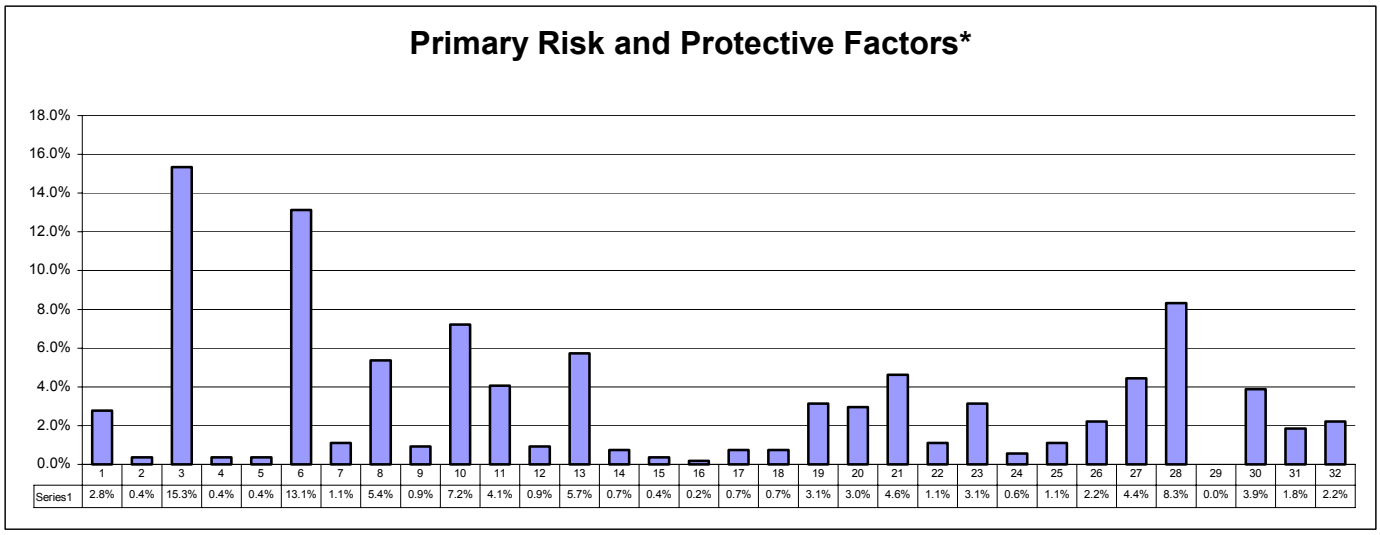
CM contractors are required to indicate which risk or protective factor is primary to the reported activity. They are also allowed to choose up to three secondary risk and/or protective factors that they are also addressing with the strategy being reported. A complete list of risk and protective factors is included as an appendix to this report.

The four most commonly selected primary risk and/or protective factors reported were:

- Community Laws and Norms Favorable to Drug Use and Violence (15 percent)
- Low Neighborhood Attachment and Community Disorganization (13 percent)
- Early Initiation of Problem Behavior (8.3 percent)
- Community Organizing Activities (7.2 percent)

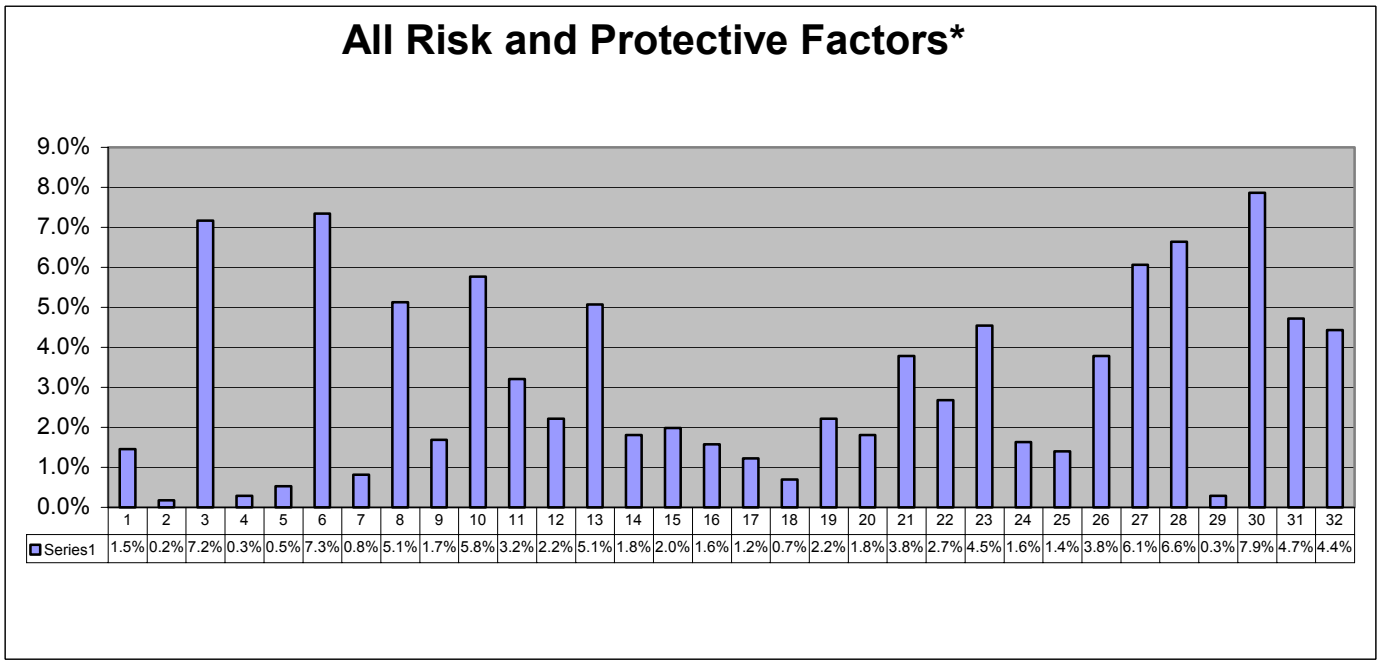
Three of the four most commonly selected risk and protective factors were from the community domain, while the remaining risk factor came from the individual/peer domain. Traditionally, risk factors have been more often identified as primary factors being addressed by programs and projects.

* LEJJ = Law Enforcement/Juvenile Justice



This year, CM was able to gather data about secondary risk and/or protective factors being addressed. The four most commonly selected risk and/or protective factors for all categories (primary and up to three secondary choices) were:

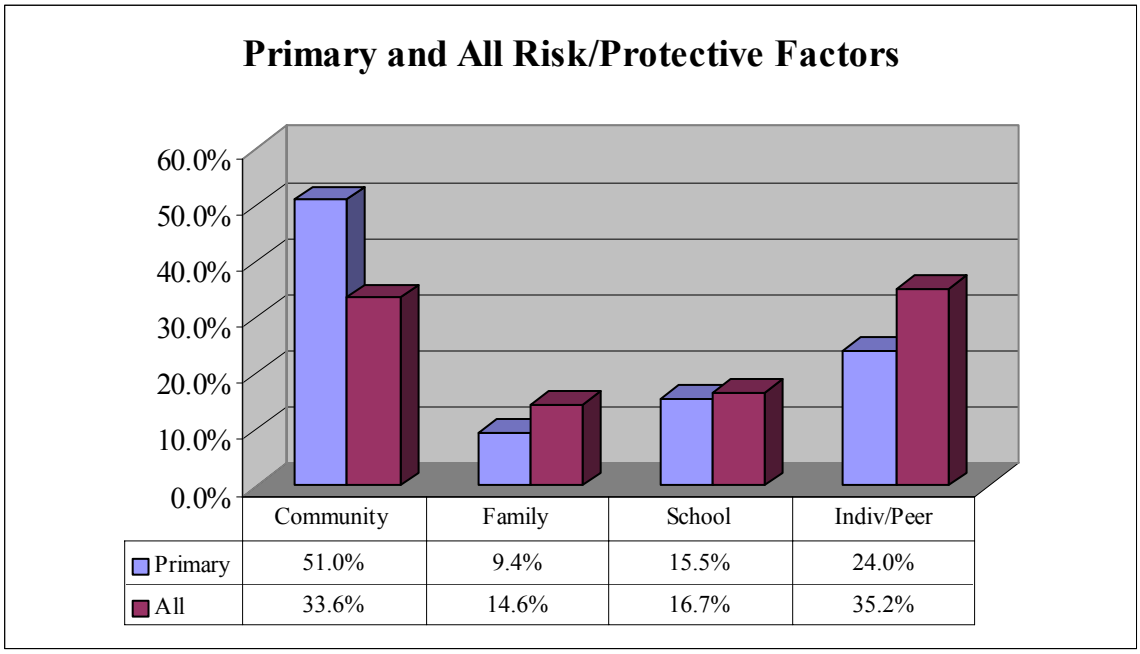
- Healthy Beliefs and Clear Standards (7.9 percent)
- Low Neighborhood Attachment and Community Disorganization (7.3 percent)
- Community Laws and Norms Favorable to Drug Use and Violence (7.2 percent)
- Early Initiation of Problem Behavior (6.6 percent)



* See Appendix G for a list of the Primary Risk and Protective Factors

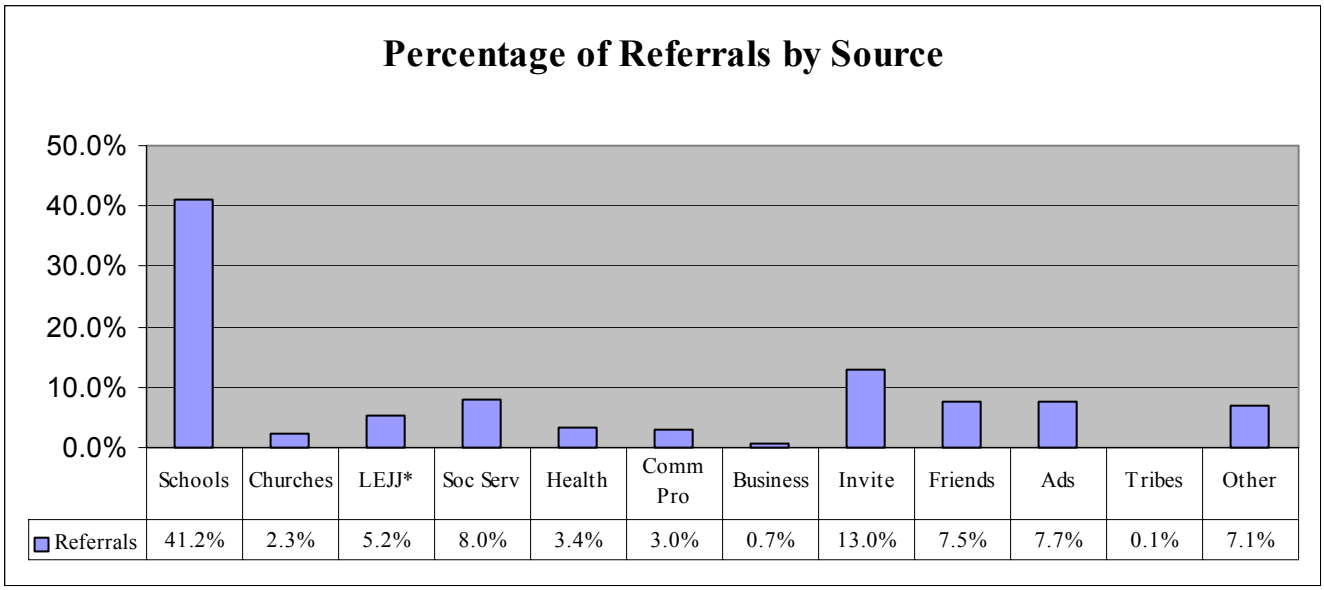
When viewed by the domain that the risk and/or protective factor represents, the results were:

	PRIMARY FACTORS	ALL FACTORS
• Community Domain Factors	(51%)	(33.6%)
• Individual/Peer Factors	(24%)	(35.2%)
• School Factors	(15.5%)	(16.7%)
• Family Factors	(9.4%)	(14.6%)



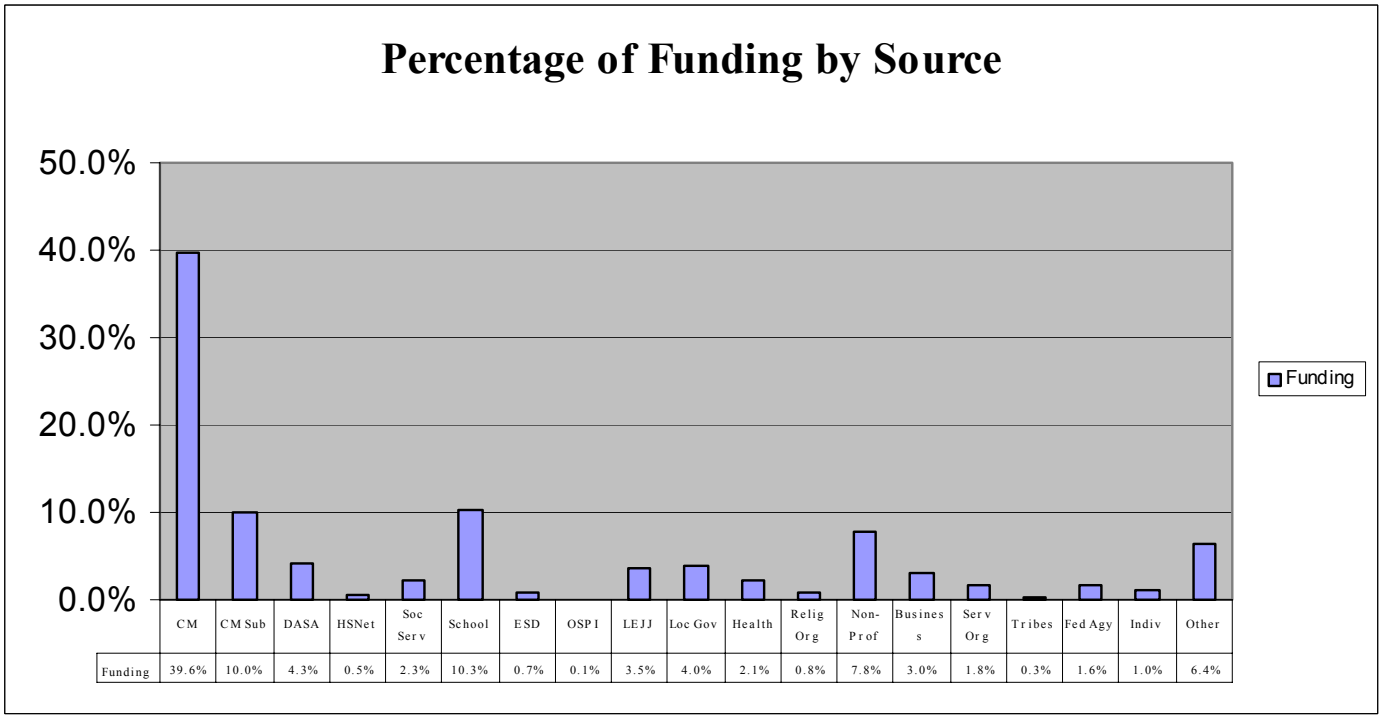
As can be seen from these graphs, while the order of the domains remains the same, the percentages vary from primary risk/protective factors to all risk/protective factors. It may be noted that while community domain risk and protective factors are the most prevalent in the primary selection (51 percent), in the overall choices, the percentage reduces to 33.6 percent. This variance may be caused by the many ways to address community issues through strategies that are primarily identified with other domains.

Sources of Referrals: Participants were referred to CM programs and projects from a variety of sources. Chief among them were schools (41 percent). Since the majority of programs are designed for youth, and since a number of those programs take place in the schools, this is not surprising. The second highest referral source was Invitation (13 percent), followed by Social Service Agencies (8 percent), Ads (7.7 percent), and Friends (7.5 percent).



Leveraging Funding: CM service providers leverage a significant portion of both personnel and funding from the community. The charts related to "Sources of Funding by Percentage", "Sources of Paid Staff", and "Sources of Volunteers" demonstrate this. A total of $1,591,621 in match was reported for the program year across the state.

CM contractors receive less than half the funding they use to provide services from CM (39.6 percent). Even if CM Subcontractors (10 percent) are included in this percentage, the total funding from CM is only 49.6 percent. Additional funding (50.4 percent**)** comes from other sources in the community. Such sources include School sources (11.1 percent), Non-Profit Agencies (7.8 percent), and DASA (4.3 percent).

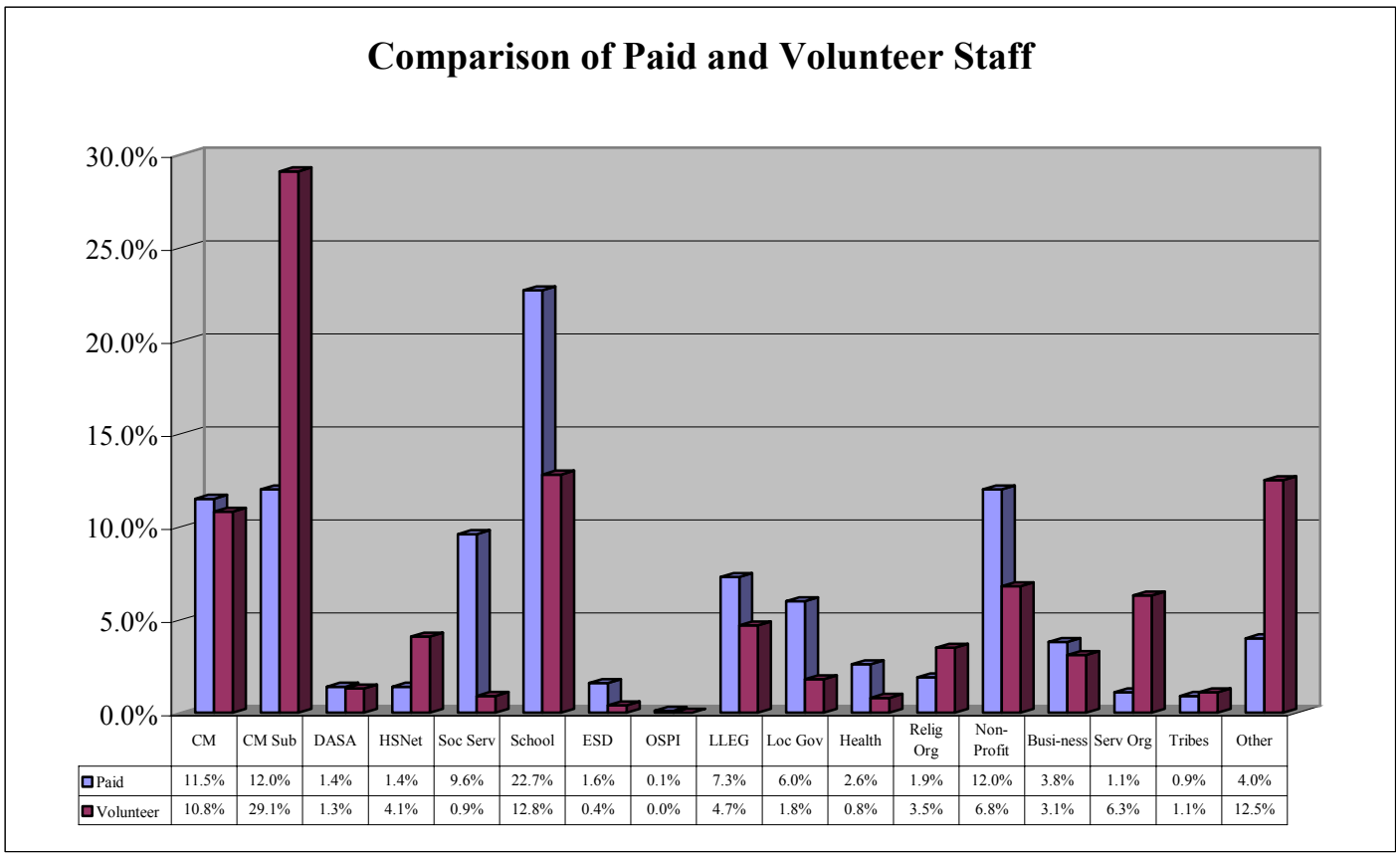


* LEJJ = Law Enforcement / Juvenile Justice

Distribution of Paid and Volunteer Staff: Because of the limited budget and resources available locally, contractors solicit both funding and staff from other organizations. Some of these staff are paid by other agencies to provide services to participants in CM programs. In addition to paid staff on other organizations' payrolls, many people provide support to local programs without monetary compensation. This year, the method for reporting the support received through paid and volunteer staff leveraged by CM was changed to provide more specific data. The results of this reporting were quite impressive.

The report shows that 76.5 percent of paid staff is provided by other agencies. The agencies that most frequently provided such support are Schools (24.4 percent), Non-Profit Agencies (12 percent), and Social Service Agencies (9.6 percent).

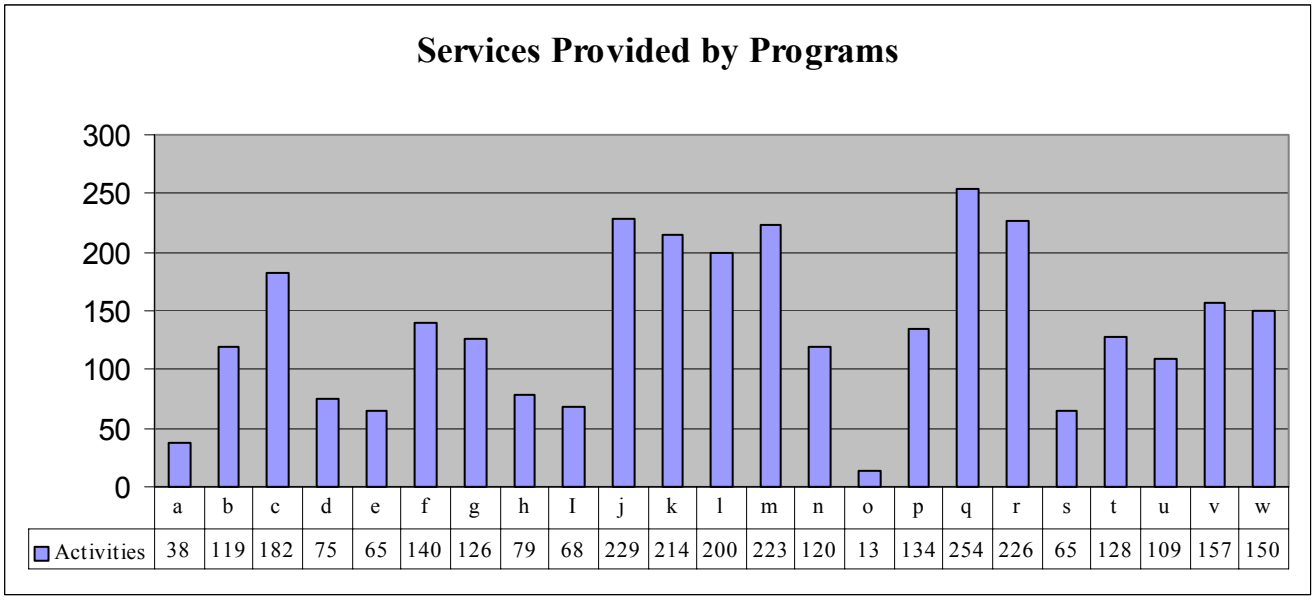
The overall ratio of volunteers to non-CM paid staff is over 2 to 1**.** The ratio of non-CM staff to CM staff is nearly 11 to 1**.** CM and CM Subcontractors recruit almost 40 percent of all volunteers to the program. Other organizations that most often provided volunteer services include Schools (22.4% paid and 13.2% volunteer), Non-Profit Agencies (12 and 6.8 percent respectively), and Community Members (4 and 12.5 percent respectively). Social Service organizations provided 9.6 percent of paid staff, but only .09 percent of volunteer staff. This is to be expected for agencies whose primary mission is providing social service resources to the community.



	CM	CM Sub	DASA	HSNet	Soc Serv	School	ESD	OSPI	LLEG	Loc Gov	Health	Relig Org	Non-Profit	Busi-ness	Serv Org	Tribes	Other
Paid	11.5%	12.0%	1.4%	1.4%	9.6%	22.7%	1.6%	0.1%	7.3%	6.0%	2.6%	1.9%	12.0%	3.8%	1.1%	0.9%	4.0%
Volunteer	10.8%	29.1%	1.3%	4.1%	0.9%	12.8%	0.4%	0.0%	4.7%	1.8%	0.8%	3.5%	6.8%	3.1%	6.3%	1.1%	12.5%

Activities provided by CM Programs: The Federal Department of Education requires the state CM Program to track the following list. These activities are identified as important by the federal grant. For purposes of this report, any given program may provide one or several services from this list.

a. Activities that protect Students traveling to and from school.
b. Activities to prevent violence related to prejudice and historical intolerance.
c. After-school and/or before-school programs.
d. Alternative education programs.
e. Anti-gang activities.
f. Community Services Projects.
g. Conflict resolution and peer mediation programs.
h. Comprehensive services and programs.
i. Curriculum acquisition and development.
j. Dissemination of information and media services.
k. Drug Prevention instruction.
l. Parent Education and involvement.
m. Program coordination with law enforcement and/or other community/state agencies and organizations.
n. Program evaluation.
o. Security Personnel and equipment.
p. Services for out-of-school youth of school age.
q. Services to youth in school.
r. Special, one-time events.
s. Surveys of drug and violence prevalence and safety.
t. Training for parents, teachers, law enforcement officials and others.
u. Violence Prevention instruction.
v. Youth/Student support services (e.g. counseling, mentoring, referrals system, etc.)
w. Youth Leadership Development.

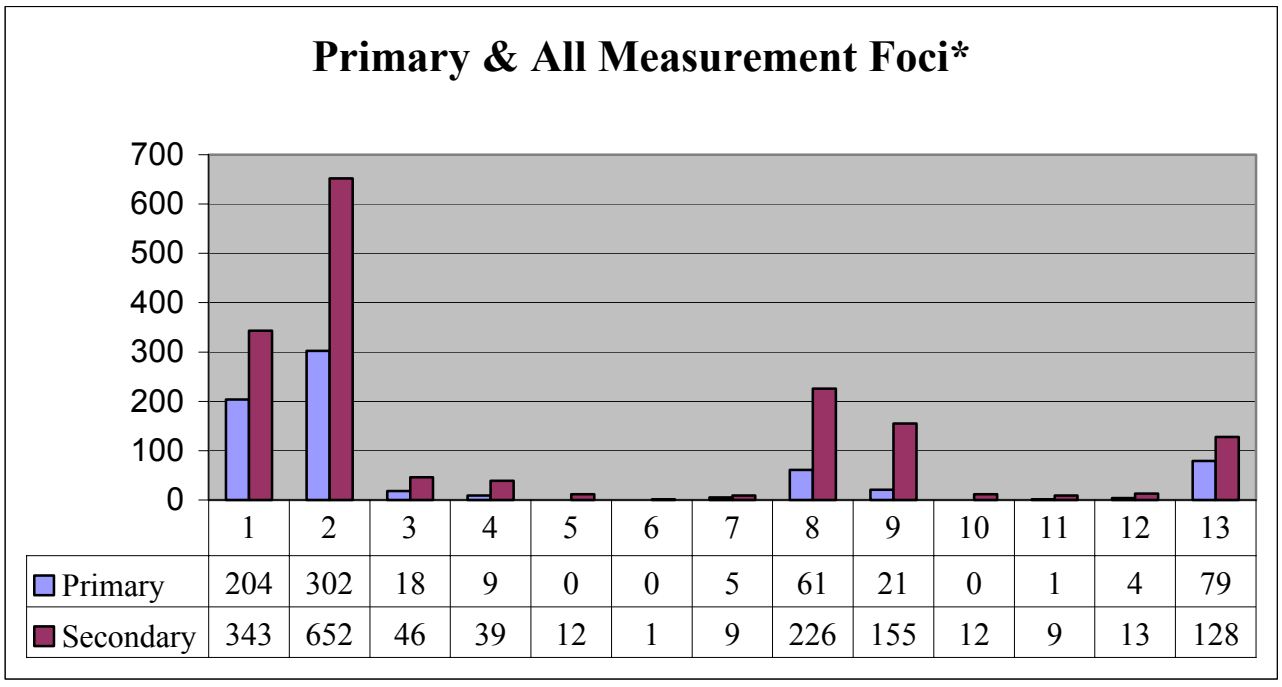


The activities from this list most commonly provided across the state are:

- Services to youth in school (254 programs)
- Dissemination of information and media services (229 programs)
- Special, one-time events (226 programs)
- Program coordination with law enforcement and/or other community/state agencies and organizations (223 programs)
- Drug Prevention instruction (214 programs)
- Parent Education and involvement (200 programs)
- After-school and/or before-school programs (182 programs)

One of the hallmarks of the CM Program statewide is the wide variety of programs provided by contractors. Not included in this list are activities and services that are provided in each county in response to their particular community's needs. For additional specifics see the Local Program Summaries.

Outcome Measures and Focus: In keeping with the Principles of Effectiveness developed by the Federal Department of Education, the state CM Program requires, as one of its components, that contractors measure at least one aspect of each program.[18] Most often, the contractor measures progress on the identified risk factor: (nearly 29 percent primary) and (nearly 21 percent aggregated), followed by the protective factor: (nearly 43 percent primary) and (39.6 percent aggregated). Other areas of focus for measurement include General Substance Abuse: (8.6 and 13.7 percent respectively), and Delinquent Behavior: (2.9 and 9.4 percent respectively).

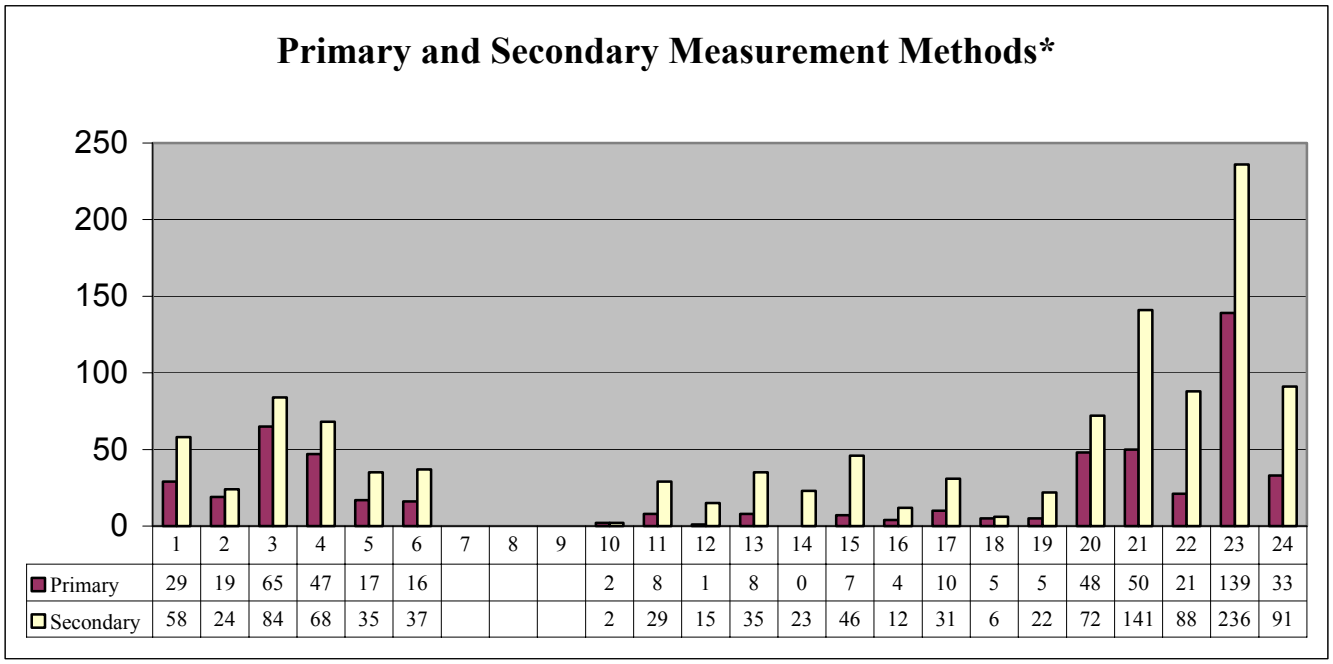


	1	2	3	4	5	6	7	8	9	10	11	12	13
Primary	204	302	18	9	0	0	5	61	21	0	1	4	79
Secondary	343	652	46	39	12	1	9	226	155	12	9	13	128

* See Appendix G for a list of the measurement foci

[18] *Principles of Effectiveness,* ESEA Title IV, Part A, Subsection 4115(a), 2002.

Contractors use a variety of measurement tools to determine the effect of the program on participants and the community. The most commonly used tools are Program Documentation (26 percent primary and 20.4 percent aggregated), Participant Satisfaction Questionnaires (26 and 12 percent respectively), and Surveys Developed by the Program (21 percent and 13 percent). Other measurement tools used include the Standardized Youth Survey (either in whole or in part), a Coalition Assessment Tool, and Focus Groups.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Primary	29	19	65	47	17	16				2	8	1	8	0	7	4	10	5	5	48	50	21	139	33
Secondary	58	24	84	68	35	37				2	29	15	35	23	46	12	31	6	22	72	141	88	236	91

* See Appendix G for a list of the Measurement Methods

The Foundation of CM's Past Outcome Evaluation Efforts

Outcome evaluation focuses upon what happens as a result of a program or activity. The analysis can examine what has resulted at a specific point during the program, at program completion, or sometime after the program has ended. Outcome evaluations answer questions such as "what happened as a result of the program after a certain time," "what happened if the program had not been available," or "what impacts the program had upon a system."

The CM Program continues to build on its outcome evaluation efforts. Within their respective funding applications, local CM Coordinators are asked to identify their outcome measurement instruments and provide detailed information concerning the timing of any pre- and post-tests administered to program participants.

To date, CM has taken several steps to bring the state and local CM Programs to full implementation of an outcome evaluation methodology that is built into the program's day-to-day functioning. The following pages will describe CM's past and current efforts in this direction.

The development of a "CM evaluation model" preceded the implementation of a formal outcome evaluation effort statewide[19]. Earlier efforts had thoroughly investigated CM operations at the county level. Some CM projects encountered difficulties in measuring program outcomes, due to the lack of a local capacity to develop appropriate research designs and the ability to conduct statistical analyses needed for proper outcome evaluation. In response to these concerns, CTED contracted with DRP in the 1998-2000 biennium to develop and implement an outcome-based evaluation among all CM projects. CTED employed the following plan of action:

1. Implementation of pilot outcome evaluations at seven CM sites (1998-99)
2. Delivery of multiple evaluation trainings (1998-2000)
3. Technical assistance to all CM Projects
4. Direct support to all CM sites in implementing their outcome evaluation efforts

The goals of the Pilot were to:

1. Develop and refine technical evaluation knowledge and procedures appropriate in the ongoing field efforts across the state
2. Better understand how evaluation activities, when managed by county-level coordinators, could be effectively implemented
3. Determine what kind of ongoing support would be required to do so

<u>Key Lessons Learned in the Pilot Evaluations</u>

- High quality outcome evaluation is possible within the context of a county-level CM effort.
- Measurement instruments specifically tailored to each site's evaluation needs either already exist or are being fine-tuned.

[19] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 50.

- Adequate research designs have been developed for most CM sites.
- The CM sites, without sustained oversight from the state, will often not initiate and sustain the expense and resources needed to conduct their evaluation efforts.

A successful by-product of the effort was the measurement instruments that were developed as a result of the pilot projects. These instruments proved useful in continuing evaluation efforts for the pilot programs and were shared with CM Programs statewide.

Outcome evaluation efforts were initiated at most CM sites in the 1999-2000 program year. By year's end, a total of 12 projects reached a stage of completion that supported an individual report on the evaluation's findings. These reports included a short description of the program, the methods of the evaluation, and the findings.

Key Lessons Learned in the 1999-2000 Outcome Evaluations

- The number of participants in the evaluation tended to be smaller than expected.
- It is often difficult to maintain the fidelity of the original program model in the ongoing day-to-day program environment.
- The most technical evaluation activities (e.g., statistical analysis) will always require outside support.
- Maintaining a control group in the typical county prevention environment is very difficult to do.

Community Mobilization's Qualitative Evaluation[20]

In 2000-2001, it was determined that CTED would shift away from using a contracted evaluation expert (DRP). In June 2001, CTED hired a full-time evaluator on staff. The evaluator's job is to oversee the continuing development and implementation of the CM Program's statewide comprehensive qualitative and quantitative evaluation efforts.

The new Program Evaluator began a qualitative evaluation of the CM Programs, using in-depth interviewing techniques. One goal of this evaluation effort was to include the perspectives of stakeholders from every county. To do so, 11 Washington State University (WSU) interns were employed to assist with the interviews within the local CM Programs. Evaluators and interns interviewed project participants, including children, youth, parents; project staff and administrators; community leaders; and others with an interest in CM. From September through December 2001, a total of 163 CM stakeholders were interviewed in 39 counties. The interviews focused on:

1. The context for how CM programs functioned within the community's economic, social and political environment.
2. How CM Programs are planned, implemented, and operated.
3. The short- and long-term outcomes of CM projects for participants and communities.

[20] Daniel M. Amos, Ph.D., *Community Mobilization in Washington State: Preliminary Evaluation Findings,* Department of Community, Trade and Economic Development, Olympia, WA, 2002.

The Social Development Model

CM has adopted the social development model and the *Communities That Care* substance abuse and prevention strategy of Hawkins, Catalano, and Associates. The model integrates four major social development theories, Control, Differential Association, Social Learning, and Social Disorganization.

Empirical studies have shown the *Communities That Care* strategies to be effective in lowering substance abuse and violence rates[21]. Local CM contractors use the social development model to assess their current substance abuse and violence issues and to design strategies that reduce the incidence of young people becoming involved in these negative behaviors, while enhancing those factors that protect them from the behavior.

Evaluation Findings

The CM evaluation reports four findings:[22]

1. Program Success and Adherence to the CTC Social Development Model: The evaluation indicates that CM is successful in supporting the development of social groups for prevention with limited public resources. Of the 28 CM programs evaluated, 96 percent (96%), or all but one program, addressed one or more risk and protective factors within the Hawkins and Catalano social development model. The remaining program mobilized their community against substance abuse and violence, but not within the Hawkins and Catalano model.

2. Program Sustainability: The evaluation gave evidence that 96 percent (96%) of the CM programs are sustained and supported by their local communities.

3. Relationship of Program Services to the Collaborative Needs Assessment: Ninety-three percent (93%) of the programs addressed the risk and/or protective factors identified through their county's Collaborative Needs Assessment process.

4. Terminology in County Needs Assessments Consistent with the Social Development Model: In the county Collaborative Needs Assessments, 51 percent (51%) of the counties (19/37) used terms for the risk and protective factors consistent with the terms in the Social Development Model.

In summary, the evaluation found that 93 percent of the programs were effectively implemented and successful in preventing substance abuse and violence. It provided additional evidence that CM's use of the social development model is successful in lessening the human costs associated with substance abuse and violence, and is therefore a good use of public resources.

Future Evaluation Efforts

During 2001-2002, CTED staff worked closely with the CM Advisory Committee and the local CM Coordinators to determine the future direction of the program's evaluation efforts. The qualitative

[21] Daniel M. Amos, Ph.D., *Community Mobilization Prevention Strategies and Outcomes: An Evaluation,* Department of Community, Trade and Economic Development, Olympia, WA, 2003.
[22] Ibid.

evaluation undertaken in 2001-2002 represents only a part of a larger effort by CTED to evaluate the varied and locally based CM Programs.

In 2002-2003, all of the 37 CM contractors will complete a Community Mobilization Scorecard to evaluate the effectiveness of their CM Boards/Coalitions, in four areas:

1. Sense of Community.
2. Mobilization Capacity.
3. Readiness for Focused Action – mobilizing people in the community who are active in substance abuse and violence prevention.
4. Conflict Resolution.

In order to validate the CM Scorecard as a measurement tool, ten CM counties have been randomly selected to have their boards/coalitions interviewed a second time by the CM Program Evaluator, using the same CM Scorecard. The intent is to compare the information collected by the Program Evaluator to the information already collected by the CM Coordinators in those ten counties. The comparison of the information collected will become the basis for validating the CM Coordinator's use of the CM Scorecard as a self-evaluation tool.

In addition, three evaluation tools have been identified for use in providing statewide CM Program data. Each county will select one of the following evaluation tools to evaluate the effectiveness of programs in one of three areas:

1. A family tension survey for evaluating program effectiveness in the family domain.
2. A rebelliousness/depression survey for measuring program effectiveness in the individual domain.
3. Focus groups for analyzing the effectiveness of programs in the school domain.

Data from the two surveys will be separately aggregated to develop statewide analyses of the effectiveness of CM programs in the Family and Individual domains. Data from focus groups across the state will be used to evaluate the effectiveness of CM-sponsored school programs.

EMERGING ISSUES

Community Mobilization is flexible and is designed to meet the particular needs of each community. While working on many different aspects of drug abuse and violence problems, CM Coordinators have found that new issues are constantly emerging. Often statewide in nature, these emerging issues may be of greater or lesser concern in any given county. CM works to address emerging issues both locally and statewide. State and local agencies often work together to develop a statewide approach. Emerging issues currently faced by CM include:

Collaborative Needs Assessment

Since 1999 CM Contractors have been required to participate in a Collaborative Needs Assessment to determine the risk and protective factors at work within their communities. To insure that the substance abuse and violence needs with the highest priority are addressed, data used to determine local needs comes from the county profiles developed by DASA, local and statewide archival data, the Washington State Survey of Adolescent Health Behaviors, and local sources. At a minimum, each county is required to conduct a joint needs assessment with DASA and CM. Other partners that are encouraged to participate include OSPI (through their ESDs), Department of Health (Tobacco Program), Family Health and Safety Networks, and the Washington Traffic Safety Commission (Reduce Under-age Drinking Project). (The last member of the group changed to the Liquor Control Board when the RUaD Program moved from WTSC to LCB).

Some groups developed common goals, objectives, and strategies to address the needs identified. It is anticipated that more counties will participate in the collaborative development of goals, objectives, and strategies as future needs assessments are conducted. The CM contractors played a pivotal role in this development and subsequent collaborative efforts.

The SIG evaluation[23] identified the following issues inherent within the needs assessment process:

- Communication from state agencies to their local constituents needs to be strengthened. Agencies' differences in administrative boundaries, fiscal agents, prevention focus, and delivery systems need to be addressed.
- Not all communities wish to engage in a joint needs assessment process.
- There are varying levels of expertise, knowledge and education for gathering and analyzing data.
- It is not always apparent where data can be found, or it may not be readily available (i.e., schools may not wish to release disciplinary action statistics; or crime or drug use statistics may not be readily available for a specific geographical area).
- Local reports that are submitted to state agencies need to be more readily accessible by both state and local staff. The content of data collected should be assessed and adjusted, as necessary, to assure continuing relevance.

[23] Christine Roberts, Ph.D., *Evaluation Report on the Spring 2001 Collaborative Assessment Process,* Washington State Department of Social and Health Services, Olympia, WA, 2001, p. vii.

Local and Statewide Networking

At the local and state level, CM works to create partnerships with multiple agencies and service providers within and outside of the prevention field. CM facilitates and provides networking capabilities between law enforcement, schools, health departments, DASA, and treatment agencies. CM brings together non-profits, businesses, religious/civic groups, tribal and various ethnic group representatives, and community members to develop strategies to address identified drug and violence prevention needs. CM contractors and state staff work with policy makers to ensure that drug and violence issues are addressed in Washington's communities. CM contractors prioritize their efforts to ensure that local networking, or *Community Organizing*, receives the support and assistance needed to continue to serve the community. Mobilizing communities and maximizing effective prevention activities are challenging.

- Territorialism: Some organizations want to dominate other agencies' efforts and/or influence the decision-making process to make choices that are contrary to the community's prioritized needs.
- Differing requirements: Expectations of funding sources vary (i.e., Community Networks, DASA, and CM), making it difficult to design comprehensive, inclusive programs. The challenge is to fulfill each funding source's requirements while maximizing each partner's contribution to the whole.
- Resource gaps: Gaps may result from funding limitations and requirements, or from a simple lack of resources. Important activities are weakened due to a lack of needed components (transportation, childcare, etc.). Sometimes the solution requires seeking partners who may fill these gaps. Creativity is necessary in identifying the resources that can respond to the need.

Outcome Measurements

Funding sources expect successful program outcomes. Positive, relevant outcome measures are more easily proven in some fields than in others. In the substance abuse and violence prevention field it is difficult to document outcomes. And since the science of measuring prevention outcomes is new, there is a steep learning curve. Programs at all levels are literally learning and modifying their outcome evaluation approaches as the science is being built.

- Skills development: prevention-program staff requires ongoing training in research methods in order to identify data that should be collected and how to collect it.
- Limited resources: funds used to provide outcome measurement expertise are diverted from serving clients. At what point does a reduction in services become a factor in preventing positive outcomes?
- Barriers encountered: schools may be resistant to releasing attendance, grade, or disciplinary action records.
- Control groups: the purpose of a control group is to demonstrate that a particular program can take credit for the results it produces. Control groups are hard to implement, partly because they are not intended to receive services.
- Prevention: how does a program prove that an individual did not use drugs/commit violence due to participation in a program? We are being asked to document something that did not happen.

- Low participant numbers: in rural communities, programs are often too small to provide a "valid" measurement. Data regarding such participants does not create a statistically meaningful result.

In 2001 – 2002, contractors were asked to interview clients, partners, and board members to determine the effectiveness and areas of improvement of at least one of their programs. This was a challenging assignment, since few of the contractors had ever done this type of evaluation. A more comprehensive report of the outcome of this effort appears elsewhere in this report.

Methamphetamine Impacts

Methamphetamine (meth) production and abuse have been on a steep rise in recent years. Washington State ranks among the top five states nationally in the production of meth. In 2001 alone, 1,890 meth lab sites were cleaned up in Washington[24]. As a result of the growing meth problem, local CM programs have added projects to address the myriad of meth concerns locally. During 2001-2002, the emphasis moved from identifying and closing "drug houses" and raising awareness regarding the harm methamphetamine brings to the community, to working to prevent the purchase of precursor drugs and to address the myriad issues involved in the clean up of lab dump sites.

At the request of a number of CM contractors, law enforcement, and environmental agencies in Washington State, Congress funded a statewide *Methamphetamine Initiative* to address the problem from multiple levels. CM contractors in 30 counties will receive funding to create local "Meth Action Teams" charged with creating countywide comprehensive strategies. Because CM approaches are rooted in community involvement, CM is viewed as having the tools and connections to accomplish the task of creating and sustaining such teams. The 30 CM Contractors will be co-conveners with their county sheriff for their county's team, and will address issues including:

- Methamphetamine labs or manufacturing facilities are growing at a rate faster than enforcing agencies can deal with them.
- Meth manufacturers have begun to move into more remote areas of the state in order to avoid detection.
- Meth manufacturers are using more creative and portable sites for production (e.g. storage units, trailers, cars, highway rest stops, etc.).
- One pound of methamphetamine product creates up to ten pounds of highly toxic refuse that is abandoned, dumped on the ground, poured into streams or sewers, or dumped down wells.
- The cost of locating, breaking down, and cleaning up meth labs far exceeds available resources.
- Meth is being widely distributed. It has gained in popularity, and education about its dangers lags far behind its availability and the promotion of its use.
- Meth addiction, while difficult, is treatable. Relapse among users in treatment is an issue at the forefront of addiction.
- During the 2001-2002 year, agencies that address the various aspects of meth issues were in the process of mobilizing into integrated teams. Several meth summits and forums were held across the state to assist in the formulation of teams and the inclusion of the divergent partners involved in this effort. CM contractors were a prominent part of this effort.

[24] *1999, 2000 and 2001 Meth Labs/Dumps,* Washington State Department of Ecology, Olympia, WA, 2002.

Inadequate and Unstable Funding

Prevention funding is unstable and, therefore, inadequate to provide a meaningful impact. CM funding has been steadily reduced over the last seven years. Prevention providers face the reality that funding may not continue. Programs and projects that are built on short-term funding cannot provide long-term results. Prevention activity results often emerge after several years of services. When programs cannot insure their existence for more than one to two years at a time, strategies must be short-term.

- Territorialism created by competition with other prevention programs for funding undermines cooperation/collaboration attempts.
- Leaving a majority of clients un-served due to lack of funds leaves problems un-addressed within the community and makes it difficult to show progress.
- In many communities, the need for service is growing faster than the resources.
- Demands placed on local CM programs to effectively demonstrate success divert resources from direct service to administrative functions. This results in staff burnout and turnover within the prevention field.
- CM programs are consistently expected to do more with less.

Most CM contractors have made the connection between being able to prove the effectiveness of their programs and success in procuring funding. Contractors came together to try to address this issue, and create ways to be able to demonstrate the effectiveness of their programs.

Science-Based Programming and Local Control

More funding sources require local contractors to use "Best Practices" and/or "Promising Approaches" from the various lists created by federal agencies. As this pressure builds, contractors must weigh the CM mandate that strategies be locally driven against the need to comply with other requirements. "Best Practices" and "Promising Approaches" are often difficult to implement for the following reasons:

1. There are at least four distinct lists of "approved" strategies, each put out by a different federal agency: Centers for Disease Control, Office of Juvenile Justice and Delinquency Prevention, the federal Department of Education, Centers for Substance Abuse Prevention. Strategies may appear on one list, but not another. They may be considered a "Best Practice" on one list and a "Promising Approach" on another.
2. "Best Practices" and "Promising Approaches" are mostly Proprietary in nature, and can be very expensive. Local contractors do not have the resources to dedicate to the acquisition of such strategies, which include the training of staff, and still have sufficient resources to provide prevention programs to their communities.
3. Many local contractors cannot reproduce the strategies with integrity due to limited resources (personnel, time, equipment or specialized materials). Some strategies require a large number of staff, or specially trained personnel in order to reproduce the program. When contractors rely on volunteers and community support to implement programs, it is more difficult to ensure reliability.
4. Local programs may not have a sufficient number of participants to demonstrate effectiveness.
5. Local communities may have an investment in locally developed strategies, which they feel are more appropriate for their populations.

Locally designed and implemented programs may have the following disadvantages:

1. They do not "fit" the risk and/or protective factors prioritized by the Needs Assessment.
2. There is no built-in outcome measurement that demonstrates effectiveness.
3. Community members may lack the expertise to develop and implement outcome measures locally. They may choose instruments that do not measure the identified outcomes. They may implement the measurement tools incorrectly.
4. The community may not possess the necessary resources to properly implement and/or analyze the measurement tools chosen. Even if the strategy seems successful, the community cannot reliably demonstrate that fact.
5. Even when the program is able to implement an appropriate outcome measurement component, it may not be viewed as "reliable" by the research community or by funding sources.
6. The rigorous procedures required to get a locally developed program selected as either a "Best Practice" or "Promising Approach" is beyond the capacity of most communities.

Contractors constantly have to balance the need to demonstrate success against the resources available to implement programming. They must also evaluate community readiness to engage in the selected programming and to provide continuing support over time. They must also ensure that resources available are wisely administered for the greatest benefit to the population. When too much of the resources are allotted to evaluation activities the amount available for prevention programs is impacted, reducing the effectiveness of the program, or reducing the number of programs a community can implement.

Cost Efficiencies and Leveraging Funds

CM funding is quite small, so most contractors have become experts in finding resources in their communities to support their prevention programming. It usually means using low-cost programs and finding partners and community members who will help support the activities developed to reduce substance abuse and violence. Because of CM's high level of networking, contractors often are involved in coordinating local resources for the best impact on their communities. However, they do not always report, or even recognize, all of the resources they have leveraged. There are several reasons for this:

1. When CM collaborates with other local agencies to apply for a grant, or when an activity is jointly funded by two or more grants within a single agency, some of their resources may have to be designated as match to that funding source in order to support the grant.
2. Other agencies also need match in order to access their funding.
3. Sometimes funding sources used to provide services require that they not be used as match for another program.
4. They do not always recognize a supportive activity or contribution actually qualifies as match when, in fact, it does (for example: a room used free of charge for prevention activities, refreshments provided by a local retailer, discounts on printing or other supplies to support the prevention activities, etc.).

Homeland Security

Since September 11, 2001, many communities have become involved in homeland security projects and issues. Contractors have found that there is a strong connection between the activities Homeland Security Projects engage in and the prevention programs being offered by contractors. While in some cases these two programs seem to compete for funding, some contractors have been able to make the connection between reducing drug-related activities and violence and public safety. Not only do drug

profits potentially help finance terrorist activities, but drug dealing and illegal drug activity also spawn a host of violent crimes that threaten public safety. A collaborative process is needed to ensure that local prevention efforts are recognized as vitally necessary within the scope of homeland security efforts.

Culturally Appropriate Prevention Programming

The number of ethnic communities across Washington State is continually growing. Joining the ranks of the more established Latino and Asian communities and Native American tribes across the state are Russian, Yugoslavian, Philippino, and other immigrants. These people often have differing cultural beliefs and actions in regard to substance abuse and violence. It is important that local contractors take into account these varying approaches to substance abuse and violence prevention among their youth. Programs that were designed to impact the average acculturated American youth may not be appropriate for these populations. In designing programs for youth of other ethnic backgrounds some strategies might include:

1. Contacting influential members of the ethnic communities to get their support for activities.
2. Listening to youth and elders of that community in designing programming.
3. Ensuring paid and volunteer staff are trained to be sensitive to the cultural differences, values and the needs of particular ethnic groups.
4. Recruit qualified members of the ethnic community to fill paid staff positions, volunteer and help in directing the program.
5. Allow the program to respond to the unique values and strengths of the particular ethnic community.